

**THIS DECISION HAS BEEN APPEALED. THE FOLLOWING
IS THE RELATED SOAH DECISION NUMBER:**

SOAH DOCKET NO. 453-05-3772.M5

MDR Tracking Number: M5-04-3880-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 07-13-04.

Dates of service 07-07-03 through 07-11-03 per Rule 133.308(e)(1) were not timely filed and will not be reviewed by the Medical Review Division.

The IRO reviewed therapeutic exercises, therapeutic activities, myofascial release, manual therapy, neuromuscular re-education and office visits rendered from 07-14-03 through 02-04-04 that were denied based upon "U".

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20-days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-19-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 97265 dates of service 07-18-03 and 07-24-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$86.00 (\$43.00 X 2 DOS).

CPT code 97250 dates of service 07-25-03 and 07-28-03 denied with denial code “F” (fee guideline MAR reduction). The carrier has made no payment. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$86.00 (\$43.00 X 2 DOS).

CPT code 97032 date of service 07-30-03 denied with denial code “F” (fee guideline MAR reduction). The carrier has made no payment. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$22.00.

CPT code 97010 date of service 07-30-03 denied with denial code “F” (fee guideline MAR reduction). The carrier has made no payment. Reimbursement is recommended per the 96 Medical Fee Guideline in the amount of \$11.00.

CPT code 99213 dates of service 12-12-03 and 01-14-04 denied with denial code “MU” (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day). The carrier’s reason for denial is invalid. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$59.00 ($\$47.20 \times 125\% = \59.00) for date of service 12-12-03 and \$60.00 for date of service 01-14-04 (MAR is $\$49.58 \times 125\% = \61.98), however, the requestor billed \$60.00.

CPT code 99212-25 dates of service 12-15-03 through 01-12-04 (7 DOS) denied with denial code “MU” (physical medicine and rehabilitation services may not be reported in conjunction with an evaluation and management code performed on the same day). The carrier’s reason for denial is invalid. Reimbursement is recommended per the Medical Fee Guideline effective 08-01-03 in the amount of \$41.91 ($\$33.53 \times 125\% = \41.91) for date of service 12-15-03 and \$44.16 ($\$35.33 \times 125\% = \44.16) for date of service 01-12-04.

CPT code 99212-25 date of service 01-02-04 denied with denial code “F”. The carrier has made no payment. Reimbursement is per the Medical Fee Guideline effective 08-01-03 in the amount of \$44.16 ($\$35.33 \times 125\% = \44.16).

Review of CPT code 99212-25 date of service 01-28-04 revealed that neither the requestor nor the respondent submitted a copy of an EOB. Per Rule 133.307(e)(2)(B) the requestor did not provide convincing evidence of carrier receipt of the providers request for an EOB. No reimbursement is recommended.

This Findings and Decision is hereby issued this 21st day of December 2004.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) and in accordance with Medicare program reimbursement methodologies effective August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 07-14-03 through 02-04-04 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 21st day of December 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

RL/dlh

MEDICAL REVIEW OF TEXAS [IRO #5259]

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NOTICE OF INDEPENDENT REVIEW DETERMINATION

TWCC Case Number:	
MDR Tracking Number:	M5-04-3880-01
Name of Patient:	
Name of URA/Payer:	
Name of Provider: (ER, Hospital, or Other Facility)	
Name of Physician: (Treating or Requesting)	

An independent review of the above-referenced case has been completed by a chiropractic doctor. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by Texas Medical Foundation, or by the application of medical screening criteria and

protocols formally established by practicing physicians. All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

Medical Review of Texas (MRT) hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to MRT.

Sincerely,

CLINICAL HISTORY

Available documentation received and included for review consists of multiple provider records dating back to 1/20/03. This includes records from Drs. W (MD), G (MD), C (MD) P (MD) and M (DC). EMG and MRI diagnostics are also available.

___ was injured at work while working as a rough mill worker for ___ on ___. She was working on a set of shutters when she developed a sudden onset of sharp left wrist pain accompanied by a 'pop'. She was initially seen by the company physician, Dr. W who placed her on modified duty, gave her a wrist splint and injected her wrist twice. She continued with difficulty and so was sent for an orthopedic consultation with Dr. G. Her wrist was again injected, apparently unsuccessfully with more pain resulting. She had EMG/MCV diagnostics through Dr. C which showed evidence of carpal tunnel entrapment. She then saw Dr. M, who assessed her DeQuervain's syndrome and started her on a rehabilitation program, ordered MRI (negative) and referred her to Dr. P for orthopedic evaluation. Dr. P recommended therapy and prescribed a splint. The patients underwent four weeks of active therapy with Dr. M between 7/10/03 and 7/20/03 with mixed results. Designated doctor evaluation (Dr. H) 8/26/03 determined the patient was not at MMI and

recommended continuation with Dr. P. Dr. P recommended surgery, and a carpal tunnel release was performed in December of 2003. The patient then underwent a course of post surgical rehab between 12/15/03 and 2/4/04 again with Dr. M. She was monitored through this time by Dr. P, who felt she was not at MMI as of 1/19/09 and then recommended a "therapeutic holiday" on 2/11/04, as it was felt that the therapy was perhaps making it worse. Problems subsequent to that dealt with elbow and shoulder pain and fighting compensability issues. MMI was determined on 03/24/04 with a 7% whole person impairment assigned secondary to neurological disorder, left wrist.

REQUESTED SERVICE(S)

Medical necessity of therapeutic exercises (97110), therapeutic activities (97530) myofascial release (97250), manual therapy (97140), neuromuscular reeducation (97112) and office visits. 7/14/03-2/4/04.

DECISION

Approved.

RATIONALE/BASIS FOR DECISION

The standard of medical necessity in Workers Comp, according to the Texas labor code 408.021 (entitlement to medical benefits) is that an employee who sustained a compensable injury is entitled to all healthcare reasonably required by the nature of the injury as and when needed. The employee is specifically entitled to healthcare that: (1) cures or relieves the effects naturally resulting from the compensable injury; (2) promotes recovery; or (3) enhances the ability of the employee to return to or retain employment.

This patient had an obviously complicated upper extremity problem, secondary to her work related injury. She was resistant to initial interventionary measures and a course of physical therapy through Dr. M was attempted. When this failed, the patient progressed to surgery. A course of post-surgical rehabilitation was then instituted.

The care was well-documented with functional improvement obtained. The care rendered was appropriate to the injury and was within accepted treatment guidelines. As such, the care rendered satisfied the above standard of medical necessity.

The above analysis is based solely upon the medical records/tests submitted. It is assumed that the material provided is correct and complete in nature. If more information becomes available at a later date, an additional report may be requested. Such and may or may not change the opinions rendered in this evaluation.

Opinions are based upon a reasonable degree of medical/chiropractic probability and are totally independent of the requesting client.

References:

Hansen DT: Topics in Clinical Chiropractic, 1994, volume one, No. 4, December 1994, pp. 1-8 with the article "Back to Basics: Determining how much care to give and reporting patient progress".
Haldeman S., Chapman-Smith D, Peterson DM., eds. Guidelines for Chiropractic Quality Assurance and Practice Parameters, Aspen: Gaithersburg, MD, 1993;
Souza T: Differential Diagnosis for a Chiropractor: Protocols and Algorithms, 1997; chapter 1, pp. 3-25.
Liebenson C. Commentary: Rehabilitation and chiropractic practice. JMPT 1996; 19(2):134140